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ABSTRACT

The report deals with the needs of all children as well as emotionally disturbed children. It outlines problem areas and makes some recommendations. Criteria and guidelines for proposals dealing with services for emotionally disturbed children and adolescents also appear. Symptoms often seen in children and adolescents are described in commonly-used terms. Treatment is suggested according to the severity of the condition. The first quarterly report of the Maryland Data System for the Handicapped is discussed. Regional estimates of needs of emotionally disturbed children and services available are indicated. A summary of the Maryland Department of Education's programs and plans for handicapped children is given. (Author)

Regional Planning Council

baltimore maryland

THESE ARE YOUR CHILDREN

A Report of the

Citizens Health Council

on

Childrens Needs

NOTE: This Report is a Working Document now under study by the Regional Planning Council.

Your Comments and Recommendations are Welcome. Please send them to the Director of Human Services Planning, Regional Planning Council, 701 St. Paul Street, Baltimore Maryland 21202.

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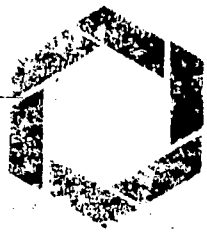
CITIZENS HEALTH COUNCIL

January, 1974



REGIONAL PLANNING COUNCIL

January 3, 1974

To: Milton H. Miller, Chairman, Regional Planning Council

From: Paul O. Becker, Chairman, Citizens Health Council

Subject: THESE ARE YOUR CHILDREN --- a Citizens Health Council Report on Children's Needs.

At its January 2, 1974 meeting, the Citizens Health Council adopted the attached report on Children's Needs and the statement below on the reports' implications to and uses by The Regional Planning Council. These documents address a large and complex set of issues. We recommend a significant program and focus for the Regional Planning Council's leadership and work. We commend these reports to your membership's serious study and favorable action. Members of the Citizens Health Council, its Mental Health Committee's Children's Needs Subcommittee will be pleased to discuss the report and implications with you.

ONE = SUMMARY OF THE REPORT

While focusing on the needs of emotionally disturbed children and adolescents, the report speaks for all children in the region

I. Findings

1. There is a discrepancy in our investment policy which runs counter to meeting the needs of children.

   a. As with many health care programs, investments are skewed heavily in support of programs providing care for children who have become severely disturbed emotionally:

      - On the condition most difficult to treat.
      - Where success is least likely to occur.
      - Which have the greatest unit costs of service.
      - Wherein we are least likely to ever achieve adequate resources of people or funds to have real impact.

   b. Proportionately little in the way of resources is committed to prevention, early intervention and treatment--- where success outcomes are more readily realized and unit service costs are least.

When you address "prevention" of emotional disturbance in children, you then address the quality of life for all children. (700,000 in the region).

2. Caring agencies and the community lack a unifying philosophy and strategy for working together.
   - The professional community and caring agencies are characterized by fragmentation and gaps in communication which impede working in concert to support children who are most at risk of becoming emotionally disturbed.

3. Many lack access to and knowledge of services providing detection, intervention and appropriate treatment.
   - "Access" includes geographic location and transportation needs, financial means, and the breaking down of social and psychological barriers to services.

II. Recommendations

1. A public policy shift (involving multiple levels of government, voluntary agencies, education and the health community) away from emphasis on repair and habilitation to improvement of the "quality of life" for all children and early detection, intervention and treatment before serious emotional disturbance occurs. The need for continued, but improved, services for severely disturbed, disadvantaged, and delinquent children and adolescents must be recognized also.

2. An increased commitment and support for thorough evaluation of programs and agencies, based on their success in aiding the child or adolescent to more successfully cope with his world, to control his problems, to gain independence to seek a meaningful life.

III. Citizens Health Council

The Citizens Health Council endorses the report, and thus assumes the responsibility of seeking Regional Planning Council endorsement also.

1. Definition of "Top Priority", (page 6).
   Prevention, early detection, and appropriate intervention and treatment of emotionally disturbed children and youth are seen as a top priority. Most emotional disturbance has its roots in problems of childhood and adolescence, and can best be treated before the condition becomes fixed.

   However, this statement in no way implies that treatment of the elderly or middle-aged be diminished, any more than the provision of services to emotionally disturbed adults or severely disturbed children.

2. Work Program
   "Recommendation" (page 6) and "Treatment Service Priorities" (page 7) are a statement of objectives which are adopted as increments to the area health plan. However, going much further at this time will require additional staff resources or a shift of staff from some other work element.

3. Criteria (page 7)
These are adopted by the CHC, to be used by the Project Review Committee in reviewing proposals.

TWO: PROPOSED STEPS TO OPERATIONALIZE CHILDRENS' NEEDS REPORT

I. DEMONSTRATION OF CONCERN

1. Policy Statement
RPC Endorsement of Statement of Concern for Children particularly emotionally disturbed and disadvantaged, noting the significant and growing numbers of such children, inadequate funding, and insufficient "child-caring" programs.

2. Program Action:
RPC development and distribution to local administrations
(a) set of planning criteria to promote "prevention"---good education, adequate play areas, recreation programs, living space, and adequate financial support for impoverished and foster children.
(b) set of criteria for adequately funding mental health and other special child caring programs (include physically handicapped)
(c) set of criteria for providing the need range of services to all.

II. CRITERIA AND GUIDELINES

1. Policy Statement
RPC endorsement of developed review criteria for specific program proposals relating to care and prevention of emotional and physical disabilities among children.

Program Action
RPC formally operationalize review criteria as part of A-95 review process regarding all relevant proposals, not just health.

III. CHILDRENS'S NEEDS WORK PROGRAM

1. Policy Statements

.RPC call for an evaluation of current programs and "categorization" of facilities by service.

.RPC convene, endorse, and participate in an intergovernmental study of child-caring agencies, focusing on need and availability of services on a local and regional level, with appropriate financing objectives.

2. Program Actions

.RPC establish a special committee or task force of its members and alternates to direct study and report as part of its Human Services Planning Work Programs, seeking appropriate funding support.

.RPC invite representatives of other agencies, organizations to work on the task force.

.RPC initiate study with staff, providing objectives, responsibility, and agendas as well as information collection.

.Products include implementation planning for areawide coordination of services and programs.

THESE ARE YOUR CHILDREN

There are 700,000 children under 18 years in the Baltimore Region. They are without voice or vote in decision-making, but their parents are becoming increasingly aware of their needs.

THE RETARDED CHILD

THE ABANDONED CHILD

THE SICK CHILD

THE UNWANTED CHILD

THE HEALTHY CHILD

THE CHILD IN TROUBLE WITH THE LAW

THE PHYSICALLY HANDICAPPED CHILD

THE SCHOOL CHILD

THIS PAPER DEALS PRIMARILY WITH . . .

. . . THE EMOTIONALLY DISTURBED CHILD

...BUT ADDRESSES THE NEEDS OF ALL CHILDREN...

Prepared by:
The Childrens Needs Subcommittee
Citizens Health Council/Regional Planning Council
Baltimore, Maryland, October 1973

THIS REPORT, PREPARED BY THE CHILDRENS NEEDS SUBCOMMITTEE IS A BROAD DOCUMENT PROVIDING A BASELINE AND DIRECTION FOR FUTURE PLANNING AS WELL AS CRITERIA AND GUIDELINES FOR REVIEW OF PROPOSALS DEALING WITH EMOTIONALLY DISTURBED CHILDREN. ACTING AS CONCERNED INDIVIDUALS, THE PROFESSIONALS INVOLVED DO NOT EACH SUBSCRIBE TO EVERY ITEM SET FORTH IN THIS REPORT, BUT ALL UNANIMOUSLY ENDORSE ITS DIRECTION AND THRUST.

This report is thoughtfully, urgently and respectfully addressed to:

The Citizens Health Council

The Regional Planning Council

State Legislative and Administrative Officials

The Community

IT CALLS FOR A POLICY IN REGARD TO CHILDREN FOR COOPERATIVE

PLANNING AND DEVELOPMENT

AND

FOR YOUR ACTION

ONE-THIRD of the Region's population is under 18 years of age.....

1970 CENSUS DATA

POLITICAL JURISDICTION	BALTIMORE CITY	ANNE ARUNDEL COUNTY	BALTIMORE COUNTY	CARROLL COUNTY	HARFORD COUNTY	HOWARD COUNTY	REGIONAL TOTAL
Age Range							
Under 5	75,765	26,187	48,859	5,636	11,103	5,686	173,236
5-9	87,346	31,866	59,621	6,636	13,254	7,300	206,023
10-14	89,457	32,233	64,821	6,797	12,483	7,165	212,956
15-17	48,741	16,562	35,926	3,566	6,412	3,615	114,822
TOTAL	301,309	106,848	209,227	22,635	43,252	23,766	707,037

PERSPECTIVE

The Regional Planning Council was established as the general planning agency for the Baltimore Region (Baltimore City and the counties of Anne Arundel, Baltimore, Carroll, Harford and Howard) in 1963, by an act of the state Legislature. The policy body consists of the highest elected local officials from each jurisdiction, planning board members plus four members appointed by the Governor. It has a multi-disciplined staff of about 70. The Regional Planning Council was designated as the Baltimore areawide comprehensive health planning agency by the Federal and State governments in 1968. Appointed by the Governor, Milton H. Miller is chairman of the Regional Planning Council.

The Citizens Health Council of representative consumers and providers of health services was formed in early 1970, to plan for improved health services in the Baltimore Region and as of July 1970, to review applications for Certification of Conformance. There is a health planning staff of 12. Paul O. Becker was elected its chairman in June, 1973.

The Childrens Needs Subcommittee formed in 1972, was designated to provide technical review and to plan for services for emotionally disturbed children, determined by this committee to be a major deficit area. It is chaired by Rachel K. Gundry, M.D.

THE SUBCOMMITTEE is composed of professionals providing services not only to emotionally disturbed children and adolescents, but, also to mentally retarded and physically handicapped children.

Originally established as a component of the Citizens Health Council Hospitals Panel to look at bed needs for all children, a high priority was placed on services (not just beds) for emotionally disturbed children.

Although institutions providing services for physically handicapped children and retarded children have been loyal participants, time and staffing have not permitted any in-depth look into unique services, plans, and problems of these groups. The formation of a specialized subcommittee or committees with staff support is needed.

SEE APPENDIX A FOR ROSTER OF MEMBERS

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INTRODUCTION AND SUMMARY

THE CHILDRENS NEEDS SUBCOMMITTEE is a strong advocate of prevention, early detection and treatment, rather than "crisis" management.

"Crisis" management, as too often practiced, involves the removal of the child from his community and incarceration in a State hospital or detention center. It does not resolve the problem nor help the child. It is extremely costly of scarce tax dollars.

Frequently, what caused the "crisis" situation to develop was the lack of prevention, early intervention and treatment services. A method must be found to channel tax dollars into these services where treatment success is greatest and expenditure per child is less.

Referral of a child to a treatment service should be based on his needs, not on color nor the size of his father's "pocketbook", nor his influence.

Public and private agencies, practitioners, and institutions should be used interchangeably as dictated by need. Public funds should follow the child to the appropriate quality treatment facility which is required.

THE SUBCOMMITTEE strongly advocates that the "child caring" agencies---the Departments of Education, Mental Hygiene, Social Services, Juvenile Services, Mental Retardation, Crippled Children, Vocational Rehabilitation--plan and implement programs jointly, based on needs of children, and that the effectiveness of present programs be evaluated.

While supporting the need for quality residential treatment when necessary, combined with therapeutic day programs for severely emotionally disturbed children and adolescents, the subcommittee abhors custodial care. Rather, it urges sufficient, accessible, sensitive out-patient treatment programs including special education, highly specialized day programs incorporating education and psychotherapeutic treatment, backed by respite care facilities, group homes, and foster care.

PREVENTION ALSO MEANS PROVIDING FOR ALL CHILDREN A "QUALITY OF LIFE" WHICH IS CONDUCIVE TO HEALTHY DEVELOPMENT.

EACH CHILD NEEDS TO FEEL THAT THE COMMUNITY CARES ABOUT HIM AND HIS FAMILY. THIS CALLS FOR THE DEVELOPMENT OF A POLICY IN REGARD TO ALL CHILDREN.

SECTION I of this report deals with the needs of all children as well as emotionally disturbed children. It outlines problem areas and makes recommendations to the Regional Planning Council, to the Citizens Health Council, and to the Childrens Needs Subcommittee itself. Criteria and Guidelines for Review of Proposals dealing with services for emotionally disturbed children and adolescents also appear in this section.

Your attention is directed to SECTION II. Symmptoms often seen in emotionally disturbed children and adolescents are described in commonly-used terms. Treatment is suggested according to the severity of the condition.

In SECTION III, the first quarterly report of the Maryland Data System for the Handicapped is discussed. Regional estimates of needs of emotionally disturbed children and services available are indicated.

A summary of the Maryland Department of Education's Programs and Plans for Handicapped Children is given.

SECTION I

A. SERVICE REQUIREMENTS FOR CHILDREN

THE GRID: PREVENTION, DETECTION, EARLY INTERVENTION AND TREATMENT OF EMOTIONAL DISTURBANCE

MAJOR AREAS OF NEED	Unborn Child	Newborn (0 - 1 years)	Toddler (1 - 3 years)	Pre-school (3 - 6 years)	Grade school (6 - 10 years)	Pubutal Youngster (10 - 12 years)	Adolescent (12 - 21 years)
ALL CHILDREN							
Genetic Concerns	X						
Nutrition	X	X	X	X	X	X	X
Awareness of child rearing needs	X	X	X	X	X	X	X
Medical care	X	X	X	X	X	X	X
Protection		X	X	X	X	X	X
Stimulation		X	X	X	X	X	X
Education				X	X	X	X
Career Planning						X	X
Help coping with adolescent sexuality						X	X
Help with independence							X
SPECIALIZED NEEDS OF EMOTIONALLY DISTURBED							
Detection of Child AT RISK		X	X	X	X	X	X
Treatment of family & child		X	X	X	X	X	X
Remediation				X	X	X	X

SOURCE: Crisis in Child Mental Health; GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, FEBRUARY, 1972

SEE APPENDIX B FOR MAJOR SITES FOR INTERVENTION

B. MEETING CHILDREN'S NEEDS

PROBLEM AREAS AND CONCLUSIONS

1. UNTIL SUCH TIME THAT THE INSTITUTIONS OF OUR SOCIETY, CHARGED WITH THE ENHANCING OF THE GROWTH AND DEVELOPMENT OF CHILDREN HAVE SUFFICIENT KNOWLEDGE AND RESOURCES TO BE SENSITIVE TO THE NEEDS OF THE GROWING CHILD AND ADOLESCENT, WE WILL CONTINUE TO BE PLAGUED WITH THE QUESTION--

   "IS IT THE CHILD WHO IS DISTURBED OR THE SYSTEM HE IS IN?"

2. Insufficient resources are devoted to maintaining "quality of life".

   The child needs to have people in his community to care about him and his family.

   In addition, he requires an environment tailored to his needs: Adequate housing, play areas, space, recreation programs, good schools and day care programs.

3. Many "child-caring" institutions do not receive sufficient community support and are not geared to provide a "quality of life" conducive to sound emotional growth.

4. PREVENTION AND EARLY DETECTION WITH APPROPRIATE TREATMENT BEFORE THE EMOTIONAL DISTURBANCE BECOMES "FIXED" PROVIDES THE GREATEST OPPORTUNITY FOR SUCCESSFUL INTERVENTION.

   The treatment of children requires the involvement of the parents or parent substitutes and their "teachers" as allies.

   The objective is to aid the child to feel more comfortable about himself and more successful in coping with his world, to bring under control his abberations and problems, to gain independence, to seek a meaningful and satisfying life.

5. Our state of understanding

   The Committee is aware of many polarizing issues that fragment rather than unite the professional community in its efforts to aid the emotionally disturbed child and adolescent and which sometimes result in elected officials being besieged by groups of conflicting experts. The issues may surface in controversy of treatment modalities, theoretical bias, status, money, and priorities. Thus our scientific advances toward greater understanding of emotional problems of childhood and adolescence may be obscured by the thunder and lightning overhead.

   The work on the Childrens Needs Subcommittee thus far suggests that the professional community in our region is aware of these polarities and can thereby hopefully move in the direction of concerted action.

6. Traditionally, mental health programs have been funded, based on number of beds. In some recent instances, other criteria have been used to determine operational funding. This trend to develop and use other criteria should be encouraged.

7. Government subsidies and grants have been awarded primarily to programs providing care for children who have become severely disturbed emotionally rather than for programs aimed at prevention and early intervention, and for drug addicts rather than "soft: drug abusers and experimentors who are at risk--Thus, money and manpower is concentrated on the disturbance which is most difficult to treat---Where treatment success is least likely to occur--And the program per patient treated is the most expensive.

   Insurance carriers, through benefit packages also have encouraged full hospitalization rather than ambulatory treatment, thus discouraging the use of early intervention techniques such as partial hospitalization, special education combined with therapy and out-patient treatment.

8. There is a vast discrepancy between treatment needs of emotionally disturbed children and the extent of appropriate treatment services available.

   Manpower: At the present level of funding, there may never be sufficient trained mental health professionals to treat all of the "emotionally disturbed children" which society is turning out.

   Money: Costs of care for the seriously emotionally disturbed child in residential treatment range from $8,000 to $35,000 per child, per year. Funding and reimbursement levels are inadequate for these services.

9. Also lacking is sufficient inter-agency cooperation, coordination, joint planning, programming and multiple funding at all levels.

10. Treatment services should be geared to community need and "present knowledge." They should be developed with the guidance of professionals within the community, rather than dictated by economic and political considerations.

    For example, the announced intent to close a training facility operated by the Department of Juvenile services because of its institutional nature and distance from the communities of its residents, brought the speculation that future uses might be for emotionally disturbed or retarded children. Yet for the vast majority of these children such a facility would be equally disastrous.

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11. The greater the distance between the child and his community....

    The longer he stays,...

    The more his care is purely custodial...

    The less the parental involvement...

    THE GREATER THE LIKELIHOOD THAT THE CHILD WILL CONTINUE TO BE UNABLE TO FUNCTION IN THE COMMUNITY!

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12. UNLESS PRIORITIES ARE SHIFTED, WE SHALL BE INCREASINGLY BURDENED WITH SEVERE DISTURBANCE AND ADDICTION, WITH INSUFFICIENT, LENGTHY AND EXPENSIVE TREATMENT, LOW SUCCESS RATES AND LONG WAITING LISTS.

13. There is a critical need to determine the effectiveness of our programs in terms of quality of care, treatment success, and cost-benefit--for programs to become publically accountable. Efforts to evaluate are being undertaken. Impediments include both insufficient financial support for thorough program evaluation and the lack of generally accepted criteria and methodology for determining treatment success, a task to be undertaken by the Childrens Needs Subcommittee.

14. ACCESSIBILITY (geographic, social, psychological, financial) is lacking for many segments of the population to quality services.

    A way must be found for financing appropriate preventive health care detection and treatment for all children.

    Programs must have sufficient staff who understand and interact with the community to break down social and psychological barriers.

    Services must be accessible to all segments of the population and arrangements must be made for the PROVISION OF TRANSPORTATION SERVICES.

15. In the final analysis, the Childrens Needs Subcommittee advocates that treatment and treatment-setting must be tailored to the individual needs of each child. For example, a moderately disturbed child might require residential treatment because his family environment may be so destructive as to prevent normal growth and the development of healthy attitudes.

C. CHALLENGES AND RECOMMENDATIONS

Since children are necessarily dependent, an advocacy role on their behalf must be introduced on all levels in regard to policy formulation and operations which either directly or indirectly affect youth.

1. TO THE REGIONAL PLANNING COUNCIL:

There is no national, state, or local policy in regard to children.

> CHALLENGE: That the Regional Planning Council in setting policy and in developing plans for the Baltimore region consider the needs of children and the effect of their decisions on the 700,000 children and youth residing in the Baltimore region.

> CHALLENGE: That the Regional Planning Council take leadership in (1) the formulation of a policy in regard to children and (2) in the development of comprehensive children's services through a joint strategy involving the child-caring agencies.

Those agencies include the following departments, administrations and programs:

- .Education
- .Juvenile Services
- .Mental Hygiene
- .Mental Retardation
- .Recreation
- .Private care-giving services: medical, social, educational
- .Vocational Rehabilitation
- .Crippled Children
- .Maternal and Child Health
- .Social Services

A cooperative inter-governmental study of the child-caring agencies
- .In regard to State and Federal objectives and financing, and
- .In relation to local needs and service capability

would represent a step toward such policy formulation. In addition, such a study could provide the basis for determining if public and private services can be restructured to more effectively meet children's needs.

The paramount need for joint input in decision-making, the interfacing of agencies and other service providers, and joint ventures at the local level is as obvious as the need for strong advocacy for the child as beneficiary, lacking both voice and vote.

For example, while recognizing that some emotionally disturbed children require residential care, the Children's Needs Subcommittee feels that most can best be helped through community-based, out-patient treatment and day programs.

While the Department of Mental Hygiene is responsible for the development of treatment services for the emotionally disturbed child, the Department of Education is responsible for educating all children, including the handicapped. Many child treatment programs combine both educational and psychotherapeutic techniques.

Educational programs and out-patient treatment are of little help to a child who has no suitable home. Both the Department of Social Services and, in some instances, the Department of Juvenile Services have responsibilities for child support payments and the development of foster and group homes.

2. TO THE CITIZENS HEALTH COUNCIL:

Manpower appropriately trained to treat the emotionally disturbed child is extremely limited.

The treatment of a seriously emotionally disturbed child requires intensive care, often lengthy in duration, and consequently very costly of both money and manpower.

The health maintenance requirements for children as enumerated in THE GRID implies the education, understanding, and sensitivity of parents and professionals of all types to the needs of children.

CHALLENGE: That the Citizens Health Council assign a top priority to the health maintenance of children and youth, including the prevention, detection, early intervention and treatment of emotional disturbance.

Great emphasis should be placed on the detection of the child "at risk":

.As an age group, the adolescent between the ages of 12 and 16 years is vulnerable.

.Socio-economically, children at the poverty level are vulnerable.

.In terms of circumstance, those at "greatest risk" are foster children and children in the care and custody of the Department of Social Services and the Department of Juvenile Services. Invariably, these children have suffered a sense of "loss" and have experienced a drastic change in their social and physical environment.

.Also "at risk" are children of alcoholic parents.

RECOMMENDATIONS on particular points of intervention include

.Increased accessibility (geographic, social, psychological, financial) to quality medical services with sufficient sensitive staff to provide early detection, early intervention, evaluation, referral, and follow-up.

.Formal inservice training programs for foster care workers, carefully designed and rigorously pursued in regard to early detection and intervention, and sensitive support to foster families.

.Increase consultation to nurseries, day care centers, schools, and groups dealing with children of alcoholic parents.

a. TREATMENT SERVICE PRIORITIES FOR EMOTIONALLY DISTURBED CHILDREN & ADOLESCENTS:

Sufficient, accessible, sensitive services and facilities providing for

.Comprehensive medical and psychological evaluation by appropriately trained professionals.

.Out-patient treatment programs including special education, highly specialized day treatment programs incorporating education and psychotherapeutic treatment, backed by respite care facilities, group homes, and foster care.

.Residential treatment combined with therapeutic day treatment programs for severely emotionally disturbed children and adolescents providing psychotherapy, education, and around-the-clock milieu therapy. Such facilities should be of a size to provide quality services efficiently but small enough to assure the integrity of the goals and objectives of the treatment program. They must be an integral part of the community and not isolated from community life.

Adequate operational funding and reimbursements from both the public and private sectors.

.Multiple agency reimbursements, and sound contractural and purchase of care arrangements.

.The level of appropriation from public sources is presently inadequate and fragmented through allocation to many agencies dealing with children.

.Some third party payors, particularly those providing major medical coverage, now pay toward treatment in psychiatrists' offices, hospitals and a few in residential treatment centers and day care programs. These coverages are insufficient to provide a sound operational base for programs because payment is partial and treatment is expensive. Furthermore, much of the population is not covered and cannot afford the cost of care.

.Adequate operational funding and reimbursement is more essential to both new program development and the continuance of existing quality programs than capital construction funds. Emphasis is placed on the development of day programs, group and foster homes in the Community major capital construction is discouraged.

b. CRITERIA AND GUIDELINES FOR REVIEW OF PROPOSALS

The program must evolve from community needs for a specific program, which will be meaningful and helpful to the population to be served. The program must be well-conceived, documented and detailed. It should include a statement of goals and objectives, a mechanism for evaluation providing for public accountability, and ultimately a policies and procedures manual.

The effectiveness of program is determined by a well-trained staff of sufficient size working as a team.

Children and adolescents who are too distressed or emotionally disturbed for public schools to manage need active skilled treatment administered by both well-trained mental health and education professionals in adequate number.

Program must extend beyond school hours for day students and residents alike. Both groups are subject to "after hours" crises and professional staff must be on duty at all times including nights and weekends. A therapeutic milieu must be provided at all times, never custodial care.

To assure continuity of program, personnel should be staggered with occasional interchange of day staff with night staff.

Proposals submitted for review should provide a detailed account of the financial aspects of the program, including:

- .Estimated cost of the program both in terms of capital investment and operating expense.
- .The source of the funds to be used in meeting capital investment and operating expenses and the actual availability and reliability of these funds.
- .A proposed budget and staffing pattern should be included as part of the application.
- .A breakdown of patient charges and relation to third party payors, and purchase of care agencies, and grant funds.

In planning for new construction and renovations, design and detailing should reflect current therapeutic and educational concepts and considerations. This includes a mix of open areas, clusters and traditional living and classrooms designed to provide maximum flexibility while assuring sufficient control.

Treatment success is dependent upon

1. Involvement of the parent or surrogate parent from the beginning of treatment.
2. Inter-agency cooperation between such agencies the Departments of Mental Hygiene, Social Services, Juvenile Services, Mental Retardation, and Education in regard to financial responsibility and appropriate placement.
3. A well-conceived, documented, and detailed treatment program including goals and objectives.
4. A well-trained and adequate staff to assure quality treatment and a continuing therapeutic milieu. In these programs which rely on teachers provided by the Board of Education, the Committee advocates that the specialized facility maintain the prerogatives of selection and supervision.

5. Assurance and/or formal agreements with agencies and third party payors in regard to the provision of services, purchase of care arrangements, grants, and third party reimbursements.

6. Formalized agreements and working relationships with other treatment programs and health care facilities providing for a continuum of linked services.

7. Inter-action with community schools.

8. Adequate after-care and follow-up.

9. Length of stay determined by each child's treatment needs rather than lack of suitable alternatives. Early discharge planning is essential.

10. A publicly accountable, continuing program evaluation related to goals and objectives and quality of care.

11. An organizational structure and policy body sensitive to community needs and receptive and acceptable to the population to be served.

Each facility should be structured to provide for

.An on-going internal planning process involving administration, staff and the policy body.

.An on-going external planning process meaningfully involving community representation and other providers of care.

3. TO THE CHILDREN'S NEEDS SUBCOMMITTEE:

While aiding and abetting in the resolution of those challenges and recommendations made to the Regional Planning Council and the Citizens Health Coucil, the Children's Needs Subcommittee will retain primary responsibility for further planning for services for emotionally disturbed children. Tasks to be accomplished include:

.Criteria for developing a method of continuing program evaluation, publicly accountable, and related to goals and objectives and quality of care.

.Strategy for the development and implementation of training programs and consultation services.

.Refinement of needs and service availability.

.Methods of attaining and training additional manpower to provide quality services.

.Strategy for involving youth in providing meaningful community services as a method of sustaining their own well-being as well as improving the mental health of the community.

SECTION II

A. ILLUSTRATIVE DEGREES OF EMOTIONAL DISTURBANCE IN CHILDREN BY SYMPTOMS

was developed at the request of
the Children's Needs Committee
by a Working Group of
that Committee:

George P. Brown, M. D., Child Psychiatrist
Montgomery County Health Department

George Cohen, Assistant Professor, Child Care
Children's Division, The Psychiatric Institute

James J. Gibbs, M. D., Child Psychiatrist
Sheppard and Enoch Pratt Hospital

Sampson Green, Jr., Social Worker
Community Health Council

William Quivers, M. D., Pediatrician
Provident Hospital

Jeanne Simmons, Social Worker
Linwood Children's Center

JoAnn Graves, Health Planner
Regional Planning Council

The PURPOSE is to delineate various levels of emotional disturbance and to suggest the kind of treatment setting appropriate to the severity of the disturbance, thus confirming the need for a range of services.

It was felt that diagnostic classification both would perpetuate the "labeling" of children, and .... would be of little value to the layman in understanding the needs of emotionally disturbed children. For these reasons, the GROUP, representing several disciplines, has attempted to explain in broadly understandable terms, the presenting problems and treatment needs of emotionally disturbed children.

The product of several lengthy sessions, ILLUSTRATIVE DEGREES OF EMOTIONAL DISTURBANCE BY SYMPTOM, a first, is presented here.

The WORKING GROUP, sanctioned by the CHILDREN'S NEEDS COMMITTEE wishes to preface its product with these remarks:

1. An individual symptom does not necessarily signify an emotionally disturbed child. The symptoms presented are those which emotionally disturbed children often manifest. There is often a "clustering"---a number of the symptoms which are present.

2. AN ABSOLUTE NECESSITY IN SUCCESSFUL TREATMENT OF EMOTIONALLY DISTURBED CHILDREN IS THE ACTIVE AND CONTINUOUS INVOLVEMENT OF THEIR PARENTS IN BOTH THE PLAN FOR AND TREATMENT OF THE CHILDREN.

3. The GROUP chose not to use the word "HYPERACTIVE" in the school-age population, because it has been overused covering both the child in a stiffling system that does not meet his needs, as well as the child who cannot "cope" with the system, regardless of how well it functions.

4. MORE THAN CASUAL DRUG USAGE IS "ESCAPISM" FROM LIFE. THIS CAN BE CAUSED EITHER BY INTERNAL EMOTIONAL PROBLEMS OR BECAUSE OF SOCIAL ADVERSITY AND/OR ECONOMIC DEPRIVATION.

5. IN ADOLESCENTS WHO SHOW SYMPTOMS OF EMOTIONAL DISTURBANCE, WHAT MAY APPEAR TO BE A PROBLEM OF THE INDIVIDUAL IS, IN ACTUALITY, THE MANIFESTATION OF SEVERE FAMILY PATHOLOGY.

ILLUSTRATIVE DEGREES OF EMOTIONAL DISTURBANCE IN CHILDREN

BY SYMPTOMS

PRE-SCHOOL CHILD, AGE 3-5 years

Note: "an individual symptom does not necessarily signify an emotionally disturbed child."

Marginal Disturbance:

.Repeatedly panics on absence of mother.

.Reverts to continuing infant behavior with arrival of new baby.

.Persistent tantrums for no apparent reason.

.Cannot cope with new situations even when with parents.

.Sleeplessness.

.Cannot be consoled after minor upsets.

.Child displays persistent discomfort when parents are interacting with one another.

.Eating of non-edible substances.

(These symptoms require early recognition, but
(can be expected to subside with minimal inter-
(vention and parental guidance. From professionals
(such as a pediatrician, nurse, nursery school or
(kindergarten director, child guidance or child
(development specialists.

Moderate Disturbance:

.At 5, will not play with other children unless he has his way.

.Shyness and fearfulness with other children.

.Persistent wetting or soiling brought on by minimal stress.

(These symptoms require active, direct inter-
(vention and assessment, a treatment plan and
(therapeutic treatment. A comprehensive medical
(and psychological evaluation by appropriately
(trained professionals is essential.

PRE-SCHOOL CHILD, AGE 3-5 years

Note: "an individual symptom does not necessarily signify an emotionally disturbed child."

Moderate Disturbance (continued):

.Child who resists change in environment and clings to familiar surroundings.

.Psychosomatic complaints.

.Persistently passive and compliant; lacking in spontaniety.

.Persistent "baby talk" and/or converses only with familiar people.

.Excessive display of affection or hostility to younger sibling.

.Unusually slow in accepting changes in his routine, such as diet, bedtime, clothing.

.Hyperactivity

Severe Disturbance:

.Severe Phobias, night terrors.

.Severe temper tantrums without obvious reason.

.Continuous depression.

.Inappropriate emotional response.

.Refuses to accept his or her gender identity.

.Has established no relationship with human beings.

(Requires a comprehensive medical and psychological evaluation and long term therapeutic treatment including a major modification in the total living situation, ranging from highly specialized day treatment programs, long-term psychoanalysis, to residential care.

PRE-SCHOOL CHILD, AGE 3-5

Note: "an individual symptom does not necessarily signify an emotionally disturbed child."

Severe Disturbance (continued):

.Makes no effort to communicate by conventional speech.

.Desires to be alone.

.Rejects casual change in environment.

.Extreme literalness; lack of imagination and fantasy concepts.

.Withdraws into fantasy.

.Lack of emotion (concreteness).

.Self abuse and self destruction.

.Repeatative bizarre motor activity.

.Does not play with toys.

.Persistent regression in toilet training.

.Little reaction to painful stimuli.

GRADE SCHOOL CHILD, AGES 6-10 years

Note: "an individual symptom does not necessarily signify an emotionally disturbed child."

Marginal Disturbance:

- .Difficulty in adjusting to school; for example, excessive dawdling, mild psychosomatic symtoms, tantrums.
- .Needs much encouragement to participate in group activities.
- .Some difficulty in forming peer relationships.
- .Lack of normal aggressiveness or overly aggressive, at times.
- .Speaks only with encouragement.
- .Excessive fastidious behavior.
- .Clowns out of insecurity.

(These symptoms require early recognition, but (can be expected to subside with minimal inter- (vention and parental guidance from professionals, (such as a pediatrician, nurse, nursery school or (kindergarten director, child guidance or child (development specialists.

Moderate Disturbance:

- .Daydreaming in class to the extent of non-participation.
- .Disruptive classroom behavior, even in a suitable environment.
- .Will not talk without extreme urging.
- .Picks on other children and cannot understand their retaliation.
- .Must always win and be first.
- .Underachievement.
- .Cruelty to animals.
- .Will only toilet at home.
- .Frequent night wetting and occasional soiling.

(These symptoms require active, direct inter- (vention and assessment, a treatment plan and (therapeutic treatment. A comprehensive (medical and psychological evaluation by (appropriately trained professionals is (essential.

GRADE SCHOOL CHILD, AGES 6-10 years

Note: "an individual symptom does not necessarily signify an emotionally disturbed child."

Severe Disturbance:

.Will not speak even with extreme encouragement.

.Gross preoccupation of one subject to the exclusion of all else.

.Severe fecal and urinary retention.

.Unmistakable school phobia.

.Continuation of behavior seen in pre-school severe disturbance.

.Repeated fire-setting.

.Does not distinguish fantasy from reality.

.Distorted image of self.

(Requires a comprehensive medical and
(psychological evaluation and long term
(therapeutic treatment including a major
(modification in the total living situation,
(ranging from highly specialized day
(treatment programs, long-term psycho-
(analysis, to residential care.

ADOLESCENT, AGES 12-16 years

Note: "an individual symptom does not necessarily signify an emotionally disturbed child."

Marginal Disturbance:

ALL ADOLESCENTS MUST BE CONSIDERED VULNERABLE, AS AT NO OTHER TIME. ALL ADOLESCENTS MAY MANIFEST MARGINAL SYMPTOMS OF DISTURBANCE, AT ONE TIME OR ANOTHER. THE SYMPTOMS, IF THEY CONTINUE, MAY THEN BE CONSTRUED AS MODERATE DISTURBANCES.

(Frequently, both adolescents and parents require counsel and guidance from appropriate professionals.)

Moderate Disturbance:

- Drastic drop in grades for no apparent reason.
- Will not communicate with any adults.
- Frequent and persistant nightmares.
- Persistant boredom and unwillingness to participate.
- Severe psychosomatic complaints.
- School phobias; resistance to leaving home and going to school.
- Chronic unhappiness, without discernible cause.
- Severe mood swings.
- Drug habituation.

(These symptoms require active, direct intervention and assessment, a treatment plan and therapeutic treatment. A comprehensive medical and psychological evaluation by appropriately trained professionals is essential.

ADOLESCENT, AGES 12-16 years

Note: "an individual symptom does not necessarily signify an emotionally disturbed child."

Severe Disturbance:

.Covert, violent behavior without any feeling of remorse.

.Obsessive/compulsive handicapping ruminatious.

.Severe and unrelieved psychosomatic complaints.

.Need to maintain a continuous "high" on drugs in order to face life.

.Gorging of food with excessive gain and/or refusal to eat with severe weight loss.

.Complete lack of interest in personal hygiene.

.Severely distorted attitude toward sex, such as a girl who ignores menstruation or adolescent who denies sex or is overtly promiscuous

.Persistant withdrawal; won't leave his or her room when anyone else is in the house.

.Does not talk to anyone.

.Deals with any stressful situation by running away.

.Minimal provocation produces violent response.

.Goes berserk over fantasized love affair or fantasized loss of social prominence.

.Sees self as a victim of ridicule and persecution even though peers and parents support him.

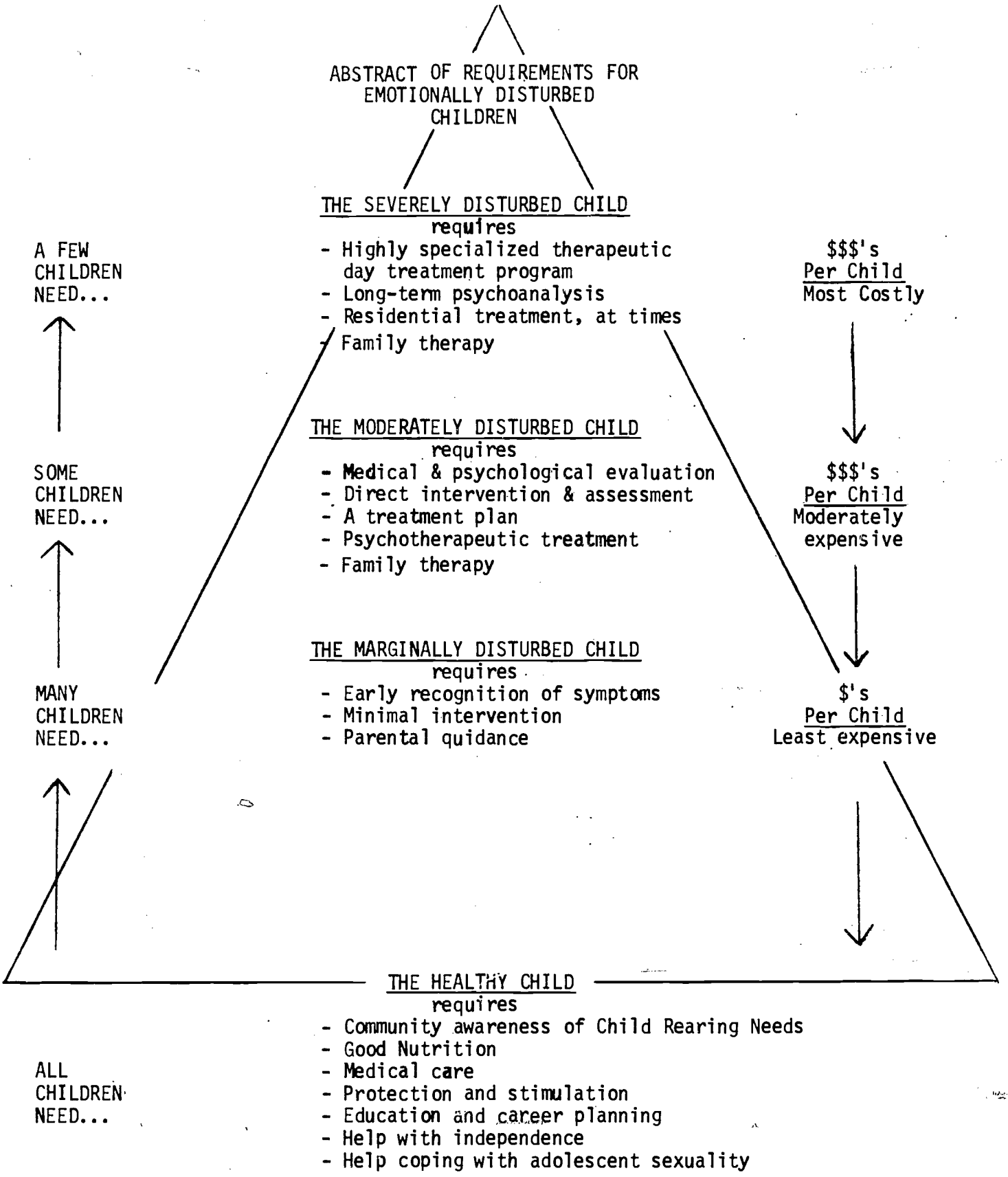
.No significant self-identity.

.Loner or blindly follows peers.

.Severe and consistent insomnia.

.Repeated threats of killing self or others.

(Requires a comprehensive medical and
(psychological evaluation and long term
(therapeutic treatment including a major
(modification in the total living situation,
(ranging from highly specialized day
(treatment programs, long-term psychoanalysis,
(to residential care.


ABSTRACT OF REQUIREMENTS FOR EMOTIONALLY DISTURBED CHILDREN
THE SEVERELY DISTURBED CHILD
requires
- Highly specialized therapeutic day treatment program
- Long-term psychoanalysis
- Residential treatment, at times
- Family therapy
A FEW CHILDREN NEED...
$$$'s Per Child Most Costly
THE MODERATELY DISTURBED CHILD
requires
- Medical & psychological evaluation
- Direct intervention & assessment
- A treatment plan
- Psychotherapeutic treatment
- Family therapy
SOME CHILDREN NEED...
$$$'s Per Child Moderately expensive
THE MARGINALLY DISTURBED CHILD
requires
- Early recognition of symptoms
- Minimal intervention
- Parental quidance
MANY CHILDREN NEED...
$'s Per Child Least expensive
THE HEALTHY CHILD
requires
- Community awareness of Child Rearing Needs
- Good Nutrition
- Medical care
- Protection and stimulation
- Education and career planning
- Help with independence
- Help coping with adolescent sexuality
ALL CHILDREN NEED...

SECTION III

A. NEEDS AND SERVICES

FOR

EMOTIONALLY DISTURBED CHILDREN

Precise data regarding needs of emotionally disturbed children in the Baltimore region (Baltimore City and the counties of Anne Arundel, Baltimore, Carroll, Harford and Howard) is not known.

Nationally, however, it is estimated that 10 percent of public school children are emotionally disturbed and in need of guidance or treatment.

In 1970..... there were 707,037 children residing in the Baltimore region. .....Of these , 533,801 are of kindergarten/school age. If the national figure of 10% is applied to the region's school age population, 53,000 children are experiencing some emotional difficulty.

According to the first report of the Maryland Data System for the Handicapped approximately 7,800 of the region's children, known to the"child caring" agencies, are probably experiencing some form of emotional disturbance. (See next topic for details.)

In 1970, there were almost 600 admissions to state mental hospitals located in the Baltimore region by children under 18 years of age.

HOSPITAL	NO. OF ADMISSIONS
Crownsville	167
Springfield	132
Spring Grove	201
Institute for Children*	62
C. T. Perkins	32
TOTAL	594

*In 1970, 82.3% of all admissions to the Institute for Children were from the Baltimore region, with 51.6% from Baltimore City and 22.6% from Baltimore County.

Private hospitals in the Baltimore region admitted approximately 300 emotionally disturbed patients under 18 years of age in 1971.

Other residential treatment centers for emotionally disturbed children, located in the Baltimore region are:

CENTER	NO. BEDS	NO. IN DAY CARE
Linwood (intake under 6 years)	16	31 (expansion to 40 soon)
Institute of Psychiatry, U. of Maryland (6-10 years)	10	12
Woodbourne (10-14 years)	31	
Sheppard Pratt Hospital (12-15)	40	

The Sheppard Pratt Hospital had 67 adolescent (age 12-15) admissions in 1972. Taylor Manor admitted 114 teenagers last year. Phipps at Johns Hopkins had 66 admissions under 18 years of age. The Institute of Psychiatry and Human Behavior, University of Maryland, had 46 admissions between 13-16 years in 1972 with an average stay of 2 months; Gundry had 5; Seton admitted 53 under 20 years of age.

In 1966, about 473,000 of the nation's children under 18 years of age received some service in a psychiatric facility. Of these children, 84% were seen on an outpatient basis and 14% were hospitalized.

Applying this to the 900 in-patient admissions in the Baltimore region, approximately 6,500 children should be receiving out-patient care from a psychiatric facility.

The children's Guild provides a pre-school day program for 102 children located in a main facility in the City with a satellite center in Towson.

Although, health department clinics and some general hospitals provide some out-patient evaluation and treatment services for emotionally disturbed children and adolescents most of the out-patient care is provided at Johns Hopkins, the University of Maryland and at Sheppard. Community mental health centers are seeing increasing numbers of children and adolescents. Among these community mental health centers, a major provider of out-patient services to Children and Adolescents is the Inner-City Community Mental Health Center which also provides mental health consultation and education services to 9 day care centers, 22 elementary schools, 5 junior high and 1 high school.

It is thought that an increasing number of children are being treated in private psychiatrists offices. Major medical insurances now pay a portion of the costs of such services and more child psychiatrists are in private practice.

There are few private schools in Maryland for children with specific learning disabilities or emotional disturbance. The Board of Education lists the following as approved schools:

	Enrollment 1972	In Balto. Region
Agnes Bruce Greig School	24	No
Center for special Education	6	Yes
Childrens Guild	102	Yes
Christ Child Institute for children	16	No
Christ Church Child Center	35	No
Edgemeade School	101	No
Linwood Children's Center	28	Yes
Mt. Airy High School	78	Yes
School for Contemporary Education	18	Yes
Sheppard Pratt Children's Center	11	Yes
John F. Kennedy Institute	26	Yes

Many children have learning disabilities. Some are excluded from the school system until "something is done". Psychological evaluation is difficult to obtain.

Out-patient services for emotionally disturbed children are very limited. There is almost no service for children aged 10-14 years.

More special education is needed in the school system.

There are few Private schools within the State which provide for emotionally disturbed children.

The Baltimore City School Board, unlike some of the counties, tends not to refer for private care those very severely handicapped children whom the school system is ill equiped to manage.

B. MARYLAND DATA SYSTEM FOR THE HANDICAPPED

The "child-caring" agencies --Education, Juvenile Services, Mental Hygiene, Mental Retardation, Preventive Medicine and Social Services are developing a Data System for the Handicapped.

The first computer print-out was completed June 30, 1973 and covers only those handicapped children known to the "child-caring" agencies. Not all localities reported and many agencies grossly under-reported. Therefore a tabulation of handicapping conditions by jurisdiction will not be given since the results could be misleading. Subsequently the Maryland Data System for the Handicapped hopes to extend reporting to pediatricians' offices and clinics and to evaluate and improve the reporting system.

The data presented raises questions which in itself is helpful in accessing present methodology and in improving future efforts. For example:

1. The Childrens Needs Subcommittee believes that children in foster care or in custody through the Departments of Social Services and Juvenile Services are children at "high risk" in regard to emotional disturbance. Yet in this Statewide report only 446 children known to the Department of Social Services are reported as having a handicapping condition. Only 13 children are so reported by the Department of Juvenile Services. THE VAST MAJORITY ARE KNOWN ONLY TO THE DEPARTMENT OF EDUCATION.

2. Why do more than half of those reported as being mentally retarded, on a Statewide basis, reside in Baltimore City? Statewide, almost 22,000 children were reported as mentally retarded, about 12,000 were reported by Baltimore City.

3. Baltimore County reported 2013 children with specific Learning/ Language Disabilities, four times more than Baltimore City which reported 521. Anne Arundel County reported 657 and Carroll County 863.

4. Anne Arundel County reported more children with Vision Disabilities than Baltimore City and as many children with psychological disturbance.

5. With Alcoholism and drug dependence touted as serious adolescent problems, why were only 28 children in the region reported as having this handicapping condition?

Because these children are known to an agency does not necessarily mean that they are obtaining the help which they need.

The Data System has its critics.

It also signifies the first product of a cooperative effort on the part of the "child-caring" agencies to take a shared look at their case-loads and themselves.

C. SERVICES TO HANDICAPPED CHILDREN

PROGRAMS AND PLANS

Maryland Department of Education. Report presented to the Childrens Needs Subcommittee, June 26, 1973, by Stanley I. Mopsik, Coordinator, Special Education.

I. MARYLAND DEPARTMENT OF EDUCATION CURRENT PROGRAM

Special Education-serving 73,000 children in Maryland
(State assistance to local departments. Budget: $30 million.)

A. IN PUBLIC EDUCATION SYSTEM

1. Seriously Handicapped - 17-18,000 children including:

   . emotionally disturbed
   . learning disabilities
   . orthopedically handicapped

   (Each local jurisdiction is eligible for an additional State contribution of up to $1,000 over and above local per pupil cost, if the local system can document that the actual program costs this amount. By Board of Education resolution, November, 1972.)

2. Educable Retarded - 16,000 children

   (as 1. above up to $1,000 over and above local per pupil cost if the local system can document its program costs.)

3. Itinerant Services (Hearing & Speech Therapy) - 30,000 children (an additional $100 per child is obtainable providing that maximum case load per therapist does not exceed 80 children. A special school such as Woodvale in Baltimore County for children with severe language difficulties is eligible for the $1,000 supplement and the additional $100.)

4. Home and Hospital Instruction 3-4,000 children per year
   (For children excluded from school. Not to exceed six hours per week per child; the local school system is reimbursed at $6.00/hr. per teacher plus transportation with a maximum of $1,000 per child.)

B. NON-PUBLIC SCHOOL EDUCATION - (where local education system does not have a suitable program for the child) -
1,900 children in and out of State
(If facility is approved by the Maryland Board of Education, $1,000 plus local pupil cost is reimbursable to parochial and non-public schools and State institutions operated by the Department of Health and Mental Hygiene, if approved. THE MONEY GOES WITH THE CHILD.)

Excess Cost Children - (Very severely handicapped) - 276 children 30 on waiting list)

a) $1.6 million appropriated in 1973; 1974 est. 404 children in need; $3.5 million appropriated.

b) 90% are severely emotionally disturbed.

c) average annual cost per child: $7,500 ranging from $2,000 - $17,000

d) These children are currently in facilities located in 20 different states.

e) 140 of the 276 children are residents of Montgomery & Prince George's County; only 30 are from Baltimore City

Because of the extreme ever-increasing cost of this program, local boards of education are being encouraged to develop local programs to bring back "excess cost" children to the public school system. It is felt that through combining psychotherapy, high teacher/pupil ratio and supportive services to families, day programs can be instituted to meet the needs of these children. Baltimore County has instituted the Greenwood School operating in a non-public school setting with eight children, three teachers, two aides, and a consulting psychiatrist at a cost of less than $5,000 per child per year; program to be increased to 16 children this fall. Montgomery and Prince George's Counties plan to institute a similar program. An inequity lies in the fact that the local school system must name specifically the children they are reclaiming from this program; although Baltimore City by many indices has a high proportion of severely emotionally disturbed children, only 30 are served by this excess costs program.

Application for obtaining Excess Costs is made in the local jurisdictions and Baltimore City's Department of Education has been notoriously disinclined to process such applications according to the Childrens Needs SubCommittee. To rectify this problem, must children be sent out of state on Excess Costs before they can be reclaimed by the locality?

There is a need to (1) involve more than one agency in meeting the needs of these children, (2) jointly fund programs, and (3) jointly develop programs for more effective and efficient services.

C. TRANSPORTATION - State funds are available to local school systems to pay for special transportation needs of handicapped children with $400,000 + budgeted for fiscal 1974.

This is a concern of the Childrens Needs Subcommittee in regard to emotionally disturbed children particularly in Baltimore City where regular transit system buses are utilized. Busing of emotionally disturbed children is a major problem.

II. MARYLAND DEPARTMENT OF EDUCATION - RECENT DEVELOPMENTS AND PLANS FOR SPECIAL EDUCATION.

A. MARYLAND DEPARTMENT OF EDUCATION APPROVAL OF SCHOOL PROGRAMS WITHIN PRIVATE AND STATE-OPERATED FACILITIES IN ORDER TO OBTAIN SPECIAL FUNDS. (Sec. 28, Article 77, Annotated Code of Maryland)

Guidelines for evaluating the educational facilities for excess cost reimbursement were approved by the Maryland Board of Education in May. This includes application, site visitation and a financial statement of costs for any non-public agency. Processing of applications will take from 60-90 days.

B. ESTABLISHMENT OF FORMAL APPEALS PROCEDURE FOR DIAGNOSIS, PLACEMENT AND EDUCATIONAL PROGRAM OF A HANDICAPPED CHILD. (H. B. 387)

Effective July 1, parents will have the right of appeal originally through an appeals procedure which must be established in each locality with ultimate appeal to a hearing board within the Maryland Department of Education.

C. COMPREHENSIVE PROGRAM FOR SPECIAL EDUCATION SERVICES FOR HANDICAPPED CHILDREN. (S. B. 649)

This law requires "the State Board of Education to promulgate by-laws for the identification, diagnosis, examination and education of children (through age 20) in need of special education services, to define these services to provide guidelines for such by-laws (by July 1, 1974)." To require local Boards of Education to develop plans for provision of special education services in accordance with State by-laws, to provide for their review and approval. (As of July 1, 1975, this law will supercede Sec. 100, enumerated in Section I of these Minutes.) Highlights of this law include the development of standards for:

1. Qualification of teachers and other personnel.
2. Procedures for diagnosis.
3. Guidelines for curricula, administration and supervision of program.
4. Provision for local, regional and/or State day and residential centers for children who cannot be served in the regular public schools (Such services could be obtained through contract with private non-profit corporations.)
5. Cooridnation with other governmental agencies.
6. Approval of placement in non-public schools when no suitable public programs are available.

Every local unit must submit a five year plan for all handicapped children, providing appropriate services.

Possible Problem Areas:

1. No funds appropriated with this Bill for the planning effort.
2. Development of appropriate by-laws.
3. Adequate operational funding.
4. Training of personnel with appropriate skills.
5. To save funds, tendency of localities to retain handicapped children within the public school system who could benefit more from a non-public facility.

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Source: Crisis in Child Mental Health: A Critical Assessment, Group for the Advancement of Psychiatry, Volume VIII, Report No. 82, February 1972

APPENDIX B

THE GRID

A. For the unborn child:

Major sites for intervention:

nutrition

medical care

genetic concerns

awareness of child rearing needs

1. Where the child is not wanted, abortion *early* in pregnancy should be an option open to all women.
2. Programs to provide a regular medical check-up for every pregnant woman.
   a. In some areas, this might imply special financial rewards for clinic attendance and achievement (keeping weight down, etc.). This would be far cheaper than the cost of care for a damaged child.
   b. Back-up programs to help out with other children in the home and with husbands in late and/or complicated pregnancy.
3. Back-up institutions (hospitals, clinics) for medical complications and for delivery.
4. Screening programs for detection of genetic damage in unborn infants.
5. Programs for nutritional support to pregnant women.
6. Programs for the education of pregnant women and concerned family members in child care and personality development.

B. For the newborn and young infant:

Major sites for intervention:

nutrition

protection

stimulation

1. Programs for regular medical well-baby check-ups for *all* babies required by law.
2. Back-up hospitals and clinics to care for sick babies.
3. Day care nursery services to give protection and care to young infants with working mothers.
4. Full infant care for cases of maternal incapacity.
   a. Adequate hospital back-up for mothers with mental or physical illness.
5. Full infant care for battered or abandoned children.
   a. Protective and treatment services for families with battered children.
6. Programs of nutritional support for *all* infants.
7. A system of designating certain infants as: AT RISK
8. Home visiting programs for infants AT RISK to provide, and to teach families to provide, optimum stimulation.

C. For the toddler:

Major sites for intervention:

protection and medical care

detection of children AT RISK

treatment for families and children

1. Detection programs for the precocious or gifted child.
2. Back-up counseling and specialized training for parents of children with unusual gifts.
3. Programs for continued provision of regular medical checkups for all children.

4. Back-up hospital and health care services.
5. Nursery school day care services for children of working mothers.
6. Residential settings for abandoned or battered children.
7. Provisions for identification of children: AT RISK.
8. Mental health outpatient facilities for identification of the nature of child and family problems.
9. Home visiting programs to support families with children AT RISK wtih emphasis on giving optimum stimulation and avoiding excessive stimulation.
10. Outpatient treatment facilities for families with troubled or limited children and for the children themselves.
11. Therapeutic nursery settings as part of such outpatient care.
12. Residential treatment settings for children with serious emotional or intellectual difficulties.

D. For the pre-school child:

1. Similar to C. 1-12 above.
2. Availability of day school programs as an integral part of the community educational system for all children from age three on up to kindergarten age.

E. For the grade-school child:

Major sites for intervention:
education
remediation

1. Programs for the detection and evaluation of unusual gifts in children and for the realization and enhancement of these talents.
2. Adequate schooling and basic health examinations for all children.
   a. Sex education, how to understand yourself, getting along in groups, how families work, etc., should be part of regular schooling.
3. Pattern for community reporting of children AT RISK by doctors, clinics, hospitals, and schools.
4. Provision of an advocate to respond to such reports by working with families and agencies to provide services.
5. Provision of adequate community resources to allow the advocate to fullfill his function.
   a. Outpatient mental health clinics for child and family.
   b. Special classes and special supports within the school system for children with emotional and intellectual difficulties.
   c. Diagnostic centers providing brief inpatient care for unusual cases.
   d. Special day schools with associated mental health support services for more disturbed children.
   e. Day hospital care.
   f. Residential treatment.
   g. Humane custodial care for the child with massive neurologic damage.
6. A pattern of family support services.
   a. Family therapy.
   b. Availability of homemakers for long-term family support.
   c. Family crisis intervention services.
   d. Back-up outpatient and inpatient psychiatric services for individual family members as needed.

F. For the pubertal youngster:

Major sites for intervention:
education
treatment
beginning career planning
coping with adolescent sexuality

1. Where talent or unusual intellect is noted, refer to advocate for help in specialized training, opportunity, and family counselling.
2. For all youngsters, adequate schooling.
   a. Sex education, family life, personality problems, how to understand yourself, etc., should be a necessary part of public school education.
3. Special classes for youngsters with emotional or intellectual problems.
4. Vocational planning and career consultation to help children and families begin to consider potential routes for future education and for training.
   a. Possibilities for early vocational training placement at end of junior high school.
5. Outpatient mental health clinic facilities.
6. Day programs such as day hospital care for youngsters needing greater support.
7. Diagnostic and crisis centers for short-term stay and brief crisis intervention.
8. Halfway houses for youth who can stay in the community but not at home.
9. Residential treatment centers.
10. General health support services.
    a. Private physicians
    b. Clinics
    c. Hospitals
11. Settings for unmarried pregnant girls:
    a. Special schools for youngsters who live at home.

b. Residential centers for youngsters who cannot live at home.

12. Advocate in juvenile court to obtain maximum community service support for youngsters brought to court.

G. For the adolescent:

Major sites for intervention:

education

training

treatment

help with independence

1. Appropriate patterns of education and training.
   a. Special schools or classes for the talented.
   b. Academic schools or classes for youngsters who would go on to college.
   c. Commercial business courses for youngsters who seek secretarial or business careers.
   d. A wide range of vocational training opportunities for appropriate candidates with built-in apprenticeship arrangements worked out with industry and labor.
   e. Special schools and classes for handicapped children, including separate facilities for children with intellectual, physical, or emotional problems.
2. Adequate specialized medical services.
   a. Practitioners and clinics trained in adolescent medicine.
   b. Full range of services for management of pregnancies of unmarried girls.
   c. VD control clinics.
   d. Family planning programs designed especially for teenagers.

3. Drug Programs.
   a. Education and counseling centers to give service to school, parents, and youngsters about drugs.
   b. Group programs for youngsters who desire to come to grips with a drug problem.
   c. Therapeutic halfway houses for youngsters who feel they cannot handle a drug problem at home.
   d. Methadone treatment clinics.
4. Community-supported teen centers with active social and recreational programs.
   a. A pattern of contests for teenagers such as drag racing, sports, cooking, sewing, crafts, science fairs, dancing, poetry, bands, etc., with meaningful rewards as a regular part of community life.
5. A range of mental health programs.
   a. Community-run hostels for runaways and transients.
   b. Outpatient clinics.
   c. Day care programs.
   d. Short-term diagnostic and crisis-care inpatient units.
   e. Residential treatment centers.
   f. Hospital beds or cottages including closed-ward care for youngsters needing more protection.